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ABSTRACT

This paper presents and evaluates a comprehensive client management system for suicide and crisis intervention services. The management system consists of five service designations: self-injury, crisis, active support, general support, and single contact. These designations determine the extent and type of activity engaged in, as well as the scope of follow-up and monitoring. As intended, self-injury clients received more contacts, longer periods of involvement, and more time in direct service. There was little difference in the length of each contact and the ability to ascertain outcome. While the management system established valuable service guidelines and priorities, it did not completely resolve approaches to some of the idiosyncratic problems presented to suicide and crisis intervention services. (Author)

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A Comprehensive Client Management System for Crisis Intervention Services

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One of the factors that distinguishes crisis intervention from more traditional therapy is the level of activity engaged in by the helping person (Farberow, 1967). The rationale for mobilizing external resources of support to people in crisis has been lucidly described by Caplan (1964). Litman (1963) emphasized the importance of action plans in suicidal crises. Most suicide prevention centers have adopted a crisis intervention model, which encourages their use of activity in responding to requests for assistance. McGee (1974) found that the degree of activity built into the service program is one of the major differences among suicide and crisis intervention centers. He suggests that every crisis service must address the question: "How active shall our program be with a client in crisis?"

In his four-phase process of crisis intervention, McGee assigns major importance to the management phase of the intervention process. It is in this phase that action plans are implemented and skills to resolve crises are employed.

Most crisis centers discover, however, a wide degree of differences among the problems presented to them. In her survey of suicide prevention centers, Fisher (1972) reports that most centers indicate that only about 20% of their calls are concerned with suicidal crises, another 70% are crises or problems other than suicide related, and some 10% are informational calls. While the types of calls vary from center to center, all programs are confronted with a wide range of requests for assistance.

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McGee suggests that crisis intervention services must serve all citizens, regardless of the type of problem presented, and each deserves equal attention. In practice, centers soon develop procedures to help them deal with special problem types. The case management system sets up the guidelines by which intervention efforts are implemented and monitored.

Even though the importance of the management phase in crisis intervention is widely accepted, there has been little attention given to the development of comprehensive case management systems. Although specific action plans are developed for each individual, are there not some guidelines to help centers focus their efforts more effectively? The importance of different procedures for different types of problems becomes more critical as the number of contacts increase, routine follow-up on all cases become impossible, and resources are spread. The management system ensures that the appropriate cases receive proper attention, and the agency's energy is not misdirected.

The purpose of this paper is to present a comprehensive client management system developed at the Alachua County Crisis Center in Gainesville, Florida, and to discuss its effectiveness during the past three years. The system was designed to help Center personnel allocate limited resources, while maintaining service accountability. The management system was also intended to help create attitudes that are supportive of the priorities established by the Center. Since the Center could not be all things to all people, it could direct its major efforts to those individuals in suicidal crises. The paper examines the degree that suicidal clients receive services different from other individuals requesting assistance.

Description of the Management System

The backbone of the management system is the assignment of clients to one of five service classifications. Crisis Center workers indicate their suggested designation, but the final determination is made by the staff member responsible for the management of client services.

I. Self-injury clients: These are individuals who have made a suicide attempt or a definite threat to injure themselves. While lethality determines the extent of immediate involvement, self-injury clients require aggressive intervention, mobilization of resources, and extensive follow-up. Specific action plans for an effective intervention are developed and monitored daily. Active follow-up continues for at least 90 days after the initiated contact.

II. Crisis clients: These are individuals who are experiencing acute situational stress, but who are not suicidal. There are indications of a precipitating event, a breakdown of usual coping skills, and an intensification of emotional affect. Management of crisis clients proceeds much like suicidal clients, except that the level of activity allowed for suicidal crises is more intensive and aggressive. Again, the focus is upon mobilization of resources, and active Center involvement until the crisis situation stabilizes. Follow-up continues until the basic crisis is resolved.

III. Active support clients: These are individuals who are upset, distressed, or confused, but not in a true crisis. These persons may require significant involvement, but do not demand the day-to-day attention that self-injury and crisis clients do. For example, a woman calls who has had a series of quarrels with her husband, she is upset, and fears that her marriage is in trouble. In addition to listening to her, Crisis Center workers may suggest marriage

counseling and request another call in a few days to see how things are going. If the lady does not call, a follow-up contact attempts to express the Center's concern and to facilitate her efforts to deal with her problems. The management plan, which is reviewed weekly, may offer specific suggestions, or may simply state to "see how things are going".

IV. General support clients: These are individuals who may be lonely, want to talk about their concerns, need emotional support, or for whom actice support is inappropriate. Many of these individuals may be in therapy, but have strong needs to verbalize their problems. General support contacts are always initiated by the client. Action plans may offer guidelines to facilitate a coordinated response, and limitations, such as the amount of time a person can talk, may be established. These records are briefly checked after each contact, and closed when the person does not contact the Center within a period of 90 days.

V. Single contact clients: These are individuals who call the Center with a problem that requires a single intervention, who remain anonymous or who are not able to be recontacted. Unless the individual calls back shortly in such a way to link contacts together, these cases are given one of the above designations for statistical purposes and closed.

Implementing the Management System

During the initial client contact, whether telephone or face-to-face, the Crisis worker, while responding as effectively as possible, makes some tentative judgment about the appropriate level of activity the Center should engage in with the client. A clear and precise action plan is developed. After the contact, the worker opens a folder summarizing the interaction and indicating

the action plan agreed upon. If immediate follow-up is anticipated, notes are left for workers to successfully coordinate the Center's efforts. Each new work day, all new client contacts are reviewed by a client services coordinator. At this time, an official assignment is designated, action plans are reviewed and augmented, and services are evaluated and monitored. Workers, therefore, can receive positive feedback as well as suggestions for improvements. The Center's future level of activity for that particular client can also be charted.

The client services coordinator also is responsible for the preparation of rolodex cards, which are cross-referenced when necessary by first name, last name, nicknames, alias, and spouse names for family crises. Records are kept according to assignment with suicide and crisis contacts filed separately from active and general support clients.

When subsequent contacts are made, the worker can quickly pull the record to check the action plan, and therefore continue a coordinated effort to assist the client. The worker will also immediately be aware of background information, especially suicidal ideation and lethality. These continuing contacts are summarized, action plans are updated, follow-up requests assigned, and then stored for immediate retrieval in a recent contact file. The system is then repeated, with the client services coordinator again checking each day on the work performed.

Limitations of the Management System

The purpose of the management system was to help Center personnel effectively allocate limited resources so that more serious crises, and especially suicidal ones, received the attention necessary without completely ignoring the need to monitor all client services provided. In implementing the system, staff members

discovered some of the limitations with the system. Once the management system became operational, it became immediately apparent that individuals seeking services are not easily placed in categories. For example, persons calling because of unhappiness with their love life, may, when questioned, admit to some suicidal ideation, although their main concern is with their love relationship. In addition, individuals calling for general emotional support may indeed experience a crisis situation that necessitates a completely different response. The most difficult problem with the system was the emotionally draining or "chronic" client. While the original design was to include these repetitive callers in the general support category, it was quickly learned that these demanding individuals, however inadequate in their functioning, were quite skilled in negating any action plans established. At the same time, many of these individuals could enter periods of high lethality when suicidal crises occurred.

The need for flexibility in the management system was also indicated by the response of Center workers. The emotionally draining clients who repeatedly threatened or attempted suicide soon exhausted the concern and goodwill of many workers. Individualized approaches emerged no matter how carefully thought-out the action plan. The level and skill of follow-up tended to vary with the likeability of the client. Furthermore, many workers have a strong dislike of any psychological "labeling" system that does not treat callers as unique individuals, however troubled. There was also some evidence that the respect for callers increased as the seriousness of their problems increased. For example, some workers were less eager to respond to active support and general support clients than to suicidal and crisis clients.

EVALUATION OF THE MANAGEMENT SYSTEM

In order to more objectively assess whether the client management system actually made a difference in the response to individuals receiving services from the Crisis Center, the records of all individuals for whom sufficient information was known to open a case between September 1, 1976 and November 30, 1976 were compared on the following variables: mean number of individual contacts from opening to closing, mean number of days of service from opening to closing, mean number of minutes of actual client contact, and mean number of minutes of service for each single contact. The results are presented in Table I.

(Place Table I about here)

Of the 335 records reviewed, 20% were designated self-injury cases, 28% were crisis, 28% were active support and 24% were general support. As indicated in Table I, the number of client contacts ranged from 8.8 per person for self-injury clients to 2.3 contacts per person for general support clients. Crisis clients, as expected, received the second highest number of contacts per person (7.4), while active support clients dropped to 4.9 contacts. While these differences are not statistically significant, it is important that clients did receive more service contact in accordance with the intention of the management system.

There was a significant difference, based upon a chi-square test, in the number of days of active involvement from case opening to case closing. As seen in Table I, the mean number of days of service increased from 6.0 for general support clients to 35.9 days for self-injury clients. Again, the number of days from the first client contact to the final client contact varied as anticipated according to the management system.

TABLE I

Comparison of client management designation with number of contacts, days of active involvement, minutes of service, and minutes per contact.

Variable	Management Designation					
	Self-injury Clients	Crisis Clients	Active support Clients	General support Clients	Total	Chi-square
N	67	94	95	79	335	-
Number of individual contacts	8.8	7.4	4.9	2.3	5.8	4.24
Days of active involvement	35.9	34.0	18.0	6.0	23.4	26.27*
Mean minutes of actual service	185.7	181.6	104.5	48.1	129.1	101.67*
Mean minutes of service per contact	17.2	20.9	19.4	24.3	20.5	1.30

* Chi-square significant at .01 level, df = 3

The mean number of minutes of service to clients also varied significantly among the four management designations, based upon the chi-square analysis. As indicated in Table I, general support clients averaged 48.1 minutes of service, active support clients averaged 104.5 minutes, crisis clients averaged 181.6, and the average for self-injury clients was 185.7.

There was no significant differences in the chi-square analysis of the mean number of minutes of client service for each contact. In fact, general support contacts averaged 24.3 minutes each compared to 17.2 minutes for self-injury clients. This is probably because the first few contacts tended to be longer then subsequent follow-up calls. Since there were more follow-up calls to self-injury clients, the average length of the calls was less than with the general support cases.

Since follow-up is an integral part of the management system, an examination was also conducted to compare self-injury clients to other clients receiving assistance in regards to case disposition at closing contact. All cases opened and closed during 1976 for which information was available were used in the analysis. Data was available on 765 individuals. After the closing contact, cases were routinely given one of the following dispositions: Problem resolved, problem diffused, client referred to another helping service- follow-up discontinued, client terminated - outcome unknown, and follow-up not possible - outcome unknown. For simplicity, problem resolved and diffused were considered together, and outcome unknown due to client termination or discontinued follow-up were considered together. The results of the analysis are presented in Table II.

(Place Table II about here)

TABLE II

Disposition at case closing of self-injury clients compared to other clients.

Disposition	Designation					
	Self-injury		Other		Total	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Problem resolved or diffused	104	43.5	240	45.6	344	45.0
Client referred to other helping service: Follow-up discontinued	61	25.5	110	21.0	171	22.3
Outcome unknown: Follow-up discontinued	74	31.0	176	33.4	250	32.7
TOTAL	239	100.0	526	100.0	765	100.0

Chi-square = 5.99; df = 2; not significant

As seen in Table II, the amount of information at case closing about problem resolution did not differ appreciably between self-injury clients and other clients. In fact, in only about 45% of the cases, was sufficient information known to consider that the clients' problems were resolved or diffused. In a large number of instances, between 31% and 33.4%, sufficient follow-up could not be completed to ascertain the individual's status. In about one-fourth the situations, follow-up was discontinued while the person was still receiving assistance from another helping service, such as a community mental health program. No judgment was made as to the effectiveness of a referral unless the client specifically indicated that things were much better than at initial contact. It appears that in spite of a great deal of effort by the Center to follow-up on the services provided, clients control to a large degree the extent of contact and the point of termination.

Summary

The evaluations of the client management system indicate that the system does achieve many of its objectives. Staff time is allocated more effectively. Service priorities for Crisis Center workers are clear. Moreover, suicidal and crisis clients receive more focused attention in relationship to active and general support clients.

The limitations of the management system are also clear. Clients are not consistent in their needs, nor do they fit into clear service categories. Furthermore, clients have a great deal of control over the services they receive from suicide and crisis intervention centers. Moreover, crisis centers do not always have complete freedom to follow-up with the services provided by other community services, and action plans cannot always be agressively implemented or fairly evaluated. Finally, the management

system is not adequate in helping with the difficult and emotionally draining client whose needs seem to transcend the resources and abilities of the Center's crisis intervention services.

Not withstanding the limitation of the system, the comprehensive client management system is a step to help suicide and crisis intervention centers implement the appropriate level of service activity to clients requesting assistance. The results so far are encouraging, although continued re-examination must continue.

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